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(F) Arbitration shall be completed by nurse and/or physician arbitrators, as indicated. Any information that was not presented at the exit conference will not be considered. Results of the arbitration will be communicated in writing to the facility within 45 days after the exit conference. If the arbitration review does not resolve differences concerning disputed items to the facility's satisfaction, the facility must request, in writing, a first level review within 10 days of receipt of the central office arbitration decision. The facility can request an on-site reassessment of the residents remaining in dispute after the arbitration decision. Otherwise, the reconsideration process will be completed without advancing to first level review.

(G) First level review will be conducted by the Chief of the Bureau of Long Term Care or designee. Any information that was not presented at the exit conference, and/or the arbitration, will not be considered. The Bureau Chief or designee will reverse the arbitrator's determination only if it is demonstrated that relevant evidence was not considered or finds the arbitrator's determination against the weight of the evidence. Results of the administrator's review and reasons, therefore, will be mailed to the facility within 45 days of receipt of the facility's request for first level review.

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(H) ~~The Department~~ DPA reserves the right to examine the validity of all assessments. A reassessment may be conducted and will serve as the basis for the facility's program reimbursement for the rate period in question. The facility may request a review of this reassessment according to the specifications above. Such an examination may be triggered by, but not limited to, assessments resulting in a rate increase or decrease of ten or more percent.

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v. Midnight Census Report

(A) The census recorded must reflect the complete activities which took place in the 24 hour period from midnight to midnight.

(B) The facility is required to compile a midnight census report daily. The information to be contained in the report includes:

(1) Total licensed capacity.

(2) Current number of residents in-house.

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(3) Names and disposition of residents not present in facility, i.e., therapeutic home visit, home visit, hospital (payable bedhold), hospital (nonpayable bedhold), other.

01/94 vi. Referrals

(A) Facility and/or physician referrals shall be made for each resident with a service and/or functional need unmet.

(B) A written facility response is required for each facility referral received.

(C) The facility response shall be forwarded to the Case Manager within 15 days of the IOC survey.

(D) The facility response must address categories of service and/or functional needs unmet and must address each resident's service and/or functional need unmet.

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vii. Quality Assurance Review

==04/98 (A) Beginning July 1, 1994, quality assurance (QA) reviews will be conducted in nursing facilities to verify that programs scored during the last Inspection of Care (IOC) and new programs established for Medicaid residents continue to meet IOC criteria as described in ~~the Department's~~ DPA's rules.

(B) Review Process. QA reviews will include the following 11 program areas from the IOC:

(1) Restorative Bathing/Grooming
(2) Restorative Clothing
(3) Restorative Eating
(4) Restorative Mobility
(5) Restorative Continence
(6) Psychosocial/Mental Status
(7) Pressure Ulcer Treatment
(8) Pressure Ulcer Prevention
(9) Psychotropic Med Reduction
(10) Passive Range of Motion
(11) Restraint Reduction and Management

(C) A random 30 percent sample of Medicaid clients residing in a facility will be selected for the review. Wherever possible, the sample will only include residents surveyed during the last IOC. When there is not a sufficient number of residents in the facility from the last IOC to derive a random 30 percent sample, the sample will be chosen from the entire Medicaid population of the facility.

(D) There may be residents who are not receiving the same services now that they were receiving at the last IOC. Resident health status may change over time, either through improvement or deterioration, and the resident may no longer benefit from a program. Consequently, the resolution process will include a provision for scoring discontinued programs where there is documentation to support that the program was discontinued appropriately because the resident could no longer benefit from it.

==04/98 (E) Notification of QA Results. Data gathered during the QA review will be evaluated by ~~the Department~~ DPA.

If the results of the QA review indicate the current service level is at least 90 percent of the service level of the last IOC, the facility will pass the QA review and no further action will be taken.

TN = 98-3 APPROVAL DATE SEP 16 1998 EFFECTIVE DATE 4-1-98

SUPERSEDES
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==04/98 F) To determine whether the 90 percent level has been maintained, ~~the Department~~ DPA will compare the dollar amount calculated from the QA review for the 11 program areas to the reimbursed amount for the same 11 program areas from the latest IOC.

G) If the QA review indicates a reduction of more than ten percent in the earned rate, the following procedures will be implemented:

(1) The facility will be notified, in writing, of the QA findings within 30 days of the QA review exit date.

==04/98 (2) Upon request from the facility, consultation will be provided by ~~Department~~ DPA field staff to assist the facility with correction of problems.

==04/98 (3) A follow-up QA review will be conducted between 90 and 120 days after the first QA exit date. The procedure defined in subsection ~~(B)~~(C) above will be used to select a 30 percent random sample for the follow-up QA review.

(H) The facility will be notified, in writing, of the follow-up QA findings within 30 days of the follow-up QA review exit date.

(I) If the follow-up QA review indicates a reduction of more than ten percent in earned rate from the last IOC, a full IOC on 100 percent of Medicaid residents will be initiated within 45 days of notification of the results from the follow-up QA review.

(J) Rate Adjustments. In any case where a 100 percent review is performed due to a reduction in services, rates will be recalculated and reduced, if indicated, based upon the full IOC results. The reduced rate will become effective on the first day of the month following the month that the full IOC exit took place. Rates will not be increased based upon IOC results.

(K) The QA review process will be used during the rate maintenance period which ends June 30, 1995.

(L) This Section shall be automatically repealed effective June 30, 1995.

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==04/98 b. ICFs/MR--Statewide Rates - ICF/MR facilities (including ICF/MR-SLC, ~~ICF/MR-15~~ ICF/MR 16 and under, ICF/MR-SNF/PED which are licensed to provide skilled nursing care for children with medical conditions requiring skilled nursing care, or developmental disabilities and/or a severe medical or physical disability, and ICF/MR with four and six beds).

ICF/MR facilities differ from other ICF facilities. Since they provide long term care for clients with developmental disabilities, there is a much heavier program component provided and, correspondingly, the medical nursing services appear to be less intense except in the ICF/MR-SNF/PED facilities. There is no reason to believe that expenses of ICF/MRs are directly comparable to those of ICFs, so the two are grouped separately.

07/96 Reimbursement is calculated according to three components: capital costs, support costs and program costs. Support costs and program costs comprise operating costs. Capital and support rates are established annually on the State's fiscal year basis, using cost report information obtained from facility financial and statistical reports. For the purpose of support rate determination, cost reports are grouped according to geographic areas which are State geographical areas. Each facility's costs from a completed fiscal year cost report are updated for inflation.

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i. Residential facilities, including distinct parts of facilities for clients with developmental disabilities (ICF/MR certification with licensure for ICF/DD, ~~ICF/DD-16~~ ICF/MR 16 and under, SLC or SNF/PED), excluding state operated facilities for individuals with developmental disabilities, will be reimbursed for an active treatment program for each client. The reimbursement method for small scale ICF/MR facilities with four and six beds is found in ~~Section III.A.3.b.ii.~~ subsection III.G. Facility program reimbursement levels will be derived by the ~~Department of Mental Health and Developmental Disabilities~~ DHS/ODD from the following four determinants which in combination will result in a total facility program per diem amount. These four determinants will be determined according to information provided in the most recent Inspection of Care (IOC) conducted by ~~Department of Public Health~~ DPH survey staff. This IOC information must be validated by the survey staff prior to utilization for payment purposes. The new reimbursement level will be effective on the first day of the quarter following a facility's IOC. Where dollar, wage or salary amounts are used, these shall be inflated to the fiscal year for which reimbursement will be made except for the period September 1, 1993, through October 12, 1993, which will be set at the levels in effect as of June 30, 1993. For the period September 1, 1993, through October 12, 1993, fringe benefits as a component of wage costs will be derived through a statewide average percentage of wages. This shall be computed as the sum of all benefits divided by the sum of all salaries paid within the State for all ICF/MR licensure groups.

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ii. Not withstanding the provisions set forth for reimbursement of long term care services, effective January 18, 1994, reimbursement rates for facilities for clients with developmental disabilities will remain at the levels in effect on January 18, 1994. An exception will be made only for requests for IOCs upon which rate determinations are based upon a Medicaid resident being transferred from a state operated developmentally disabled facility to a community setting. These requests will be considered on a case-by-case basis.

IOCs will continue to be conducted for data gathering purposes only. The data will not be used to make adjustments to the facility rate.

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(A) Minimum Staffing

(1) Direct Services - Facilities must be in compliance with the Health Care Financing Administration's (HCFA) minimum average daily staffing standards relative to client population according to each individual's overall level of functioning:

Overall Level of Functioning	FTE* Staff : Client Ratio
Mild	1:5
Moderate	1:2.5
Severe or Profound	1:2

*FTE = Full Time Equivalent

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Determination of levels of functioning of clients with mental retardation and related conditions, in accord with the definition of the American Association of Mental Retardation, will include an assessment of adaptive behaviors using a nationally standardized, ~~Department~~ DHS/ODD approved assessment instrument, such as the Scales of Independent Behavior (SIB) or the Inventory for Client and Agency Planning (ICAP). Such an assessment instrument will be utilized by at least one Qualified Mental Retardation Professional (QMRP) to evaluate each client's functional skills and adaptive behaviors. The level of functioning determination will also include an assessment of intellectual functioning as measured by a standardized, full scale, individual intelligence test such as the Stanford Binet and WAIS-R. Such an assessment must be administered by a psychologist who is registered in Illinois under the Illinois Psychological Act (Illinois Department of Professional Regulation).

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The amount for Direct Services for these staffing ratios shall be obtained by (a) determining the number of clients within each overall level of functioning, (b) dividing each number by the client component of the staff: client ratio, (c) summing these quotients, (d) multiplying the sum by the aide hourly wage factor, and then by 2080 (52 weeks times 40 hours per week), to obtain a total annual Direct Service cost, and (e) dividing this total by 365 days and then by the number of clients to obtain the amount for Direct Services per client per day.

For example, if a facility serves 40 clients in the mild level of functioning, 30 clients in the moderate level of functioning, and 30 clients in the severe/profound level of functioning, the number of FTE Direct Services staff will be (40 divided by 5) + (30 divided by 2.5) + (30 divided by 2) = 35. If the aide hourly wage is $5.00, the total annual cost will be 35 x $5 x 2080 = $364,000. The amount for FTE Direct Services per client per day will then be $364,000 divided by 365 divided by 100 = $9.97.

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In ~~ICF/DD-16~~ ICF/MR 16 and under facilities, the foregoing calculation is modified such that the facility may receive an amount for up to an additional .5 FTE Direct Service. The additional FTE Direct Service is determined by multiplying .5 FTE by the proportion found by the ratio of the number of Medicaid eligible clients in the severe/profound level of functioning divided by the total number of eligible clients. This will not apply for the period beginning September 1, 1993 through October 12, 1993.

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(2) Licensed Nurses

Facilities must be in compliance with HCFA and/or ~~Illinois Department of Public Health (IDPH)~~ DPH staffing standards relative to facility type.

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(a) An ICF/MR (ICF/DD, SLC, SNF/PED but excluding ~~ICF/DD-16~~ ICF/MR 16 and under) licensed for a population of 90 or fewer clients, none of whom require services under Levels II and III of Specialized Care-Health and Sensory Disabilities, will be reimbursed for a minimum of 4.8 FTE nurses. A facility with only such a population which has a licensed capacity greater than ninety (90) clients will be reimbursed for additional FTE nurses according to the following Table:

Licensed Capacity, Client Type	FTE Nurse : Client Ratio
Greater than 90 clients with no Specialized Care-Health and Sensory Disabilities needs under Levels II and III	1:18.75

==04/98

(b) An ICF/MR (ICF/DD, SLC, SNF/PED but excluding ~~ICF/DD-16~~ ICF/MR 16 and under) licensed for a population of 30 or fewer clients, all of whom require services under Level(s) II and/or III of Specialized Care - Health and Sensory Disabilities, will be reimbursed for a minimum of 4.8 FTE nurses. A facility with only such a population which has a licensed capacity greater than thirty (30) clients will be reimbursed for additional FTE nurses according to the following table:

Licensed Capacity, Client Type	FTE Nurse : Client Ratio
Greater than 30 clients requiring Specialized Care - Health and Sensory Disabilities under Level(s) II and/or III	1:6.25

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(c) An ICF/MR (ICF/DD, SLC, SNF/PED but excluding ~~(ICF/DD-16~~ ICF/MR 16 and under) which has a licensed capacity of 30 clients or more, some of whom require services under Level(s) II and/or III of Specialized Care - Health and Sensory Disabilities, and some of whom do not require such services, will be reimbursed at a minimum of 4.8 FTE nurses for non Specialized Care individuals plus additional FTE nurses, up to a maximum of a 1:6.25 ratio, according to the following Table:

Client Type	FTE Nurse:Client Ratio
Clients requiring Specialized Care - Health and Sensory Disabilities under Level(s) II and/or III	1:6.25
Clients with no Specialized Care needs under Levels II and III	1:18.75

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For example, for a facility with a licensed capacity of 42 clients, 15 of whom require services under Level(s) II and/or III, and 27 of whom do not require such services, the number of FTE nurses will be (15 divided by 6.25 = 2.40) + (27 divided by 18.75 = 1.44, however, reimbursement will be calculated at the minimum of 4.8) = 7.2 utilizing the maximum client ratio allowed, the facility will be reimbursed for 6.72 FTE nurses (42 divided by 6.25 = 6.72).

==04/98

(d) Licensed nurses are not required in an ~~ICF/DD-16~~ ICF/MR 16 and under if none of the clients require a physician's medical care plan of treatment.

==04/98

An ~~ICF/DD-16~~ ICF/MR 16 and under which has 8 or fewer clients with medical care plans of treatment but who do not require services under Specialized Care - Health and Sensory Disabilities, Level(s) II and/or III, will be reimbursed for .5 FTE nurse. A facility with 9 or more such clients will be reimbursed for one (1) FTE nurse.